Indiana State Department of Health

AND PLAN OF CORRECTION IDENTIFICATION NU		(X1) PROVIDER/SUPPLIER/C		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		IDENTIFICATION NOMBE	IN.				
		012591		B. WING		01/23/2013	
			STREET ADDR	RESS, CITY, STA	TE. ZIP CODE	01/2	0/2010
NAME OF TH	OVIDER OR SOLT EIER			MET AVE STE			
DINAMIC HEALTH CARE INC			MUNSTER,				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECT		(X5)
PREFIX TAG		CY MUST BE PRECEDED BY FU LSC IDENTIFYING INFORMATION		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETE DATE
IAG	TAG TREGGERIORI OR EGG IDERTIT TING INTO ORIGINA			IAG	DEFICIENCY)		
N 000	0 Initial Comments			N 000			
	This was a state hom	ne health complaint					
	investigation.						
	Complaint # IN00122	2358 - Unsubstantiated:					
	Lack of sufficient evid	dence. State deficienci	es				
	unrelated to the allegation were cited.						
	Facility #: 12591. Medicaid Vendor #: N/A. Survey Dates: 1/22 - 23/13.						
	Medical Records Rev	viewed: 3.					
	Surveyor: Janet Bran	ndt, RN, PHNS.					
	Quality Review: Joyce Elder, MSN, BSN, RN January 28, 2013 This survey was modified as the result of an IDF 2/18/13. je		I				
			IDR				
N 446	410 IAC 17-12-1(c)(3) Home health agency administration/management		N 446			2/11/13	
	Rule 12 410 IAC 17-12-1(c)(3)						
	the supervising physi required by subsection (3) Employ qualified adequate staff educa	ministrator, who may als ician or registered nurse on (d), shall do the follow personnel and ensure tion and evaluations.	,				
	This RULE is not met as evidenced by: Based on personnel record and policy review a interview, the administrator failed to employ a qualified alternate director of nursing for 1 of 1		a				

Indiana State Department of Health

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIEF IDENTIFICATION NUM			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED				
	042504			B. WING		01/23/2013			
NAME OF PROVIDER OR SUPPLIER STREET			STREET ADDE	I RESS. CITY. STA	TE. ZIP CODE	01/2	3/2013		
DINAMIC HEALTH CARE INC.			7826 CALU	ALUMET AVE STE C ER, IN 46321					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	CTION SHOULD BE COMPL O THE APPROPRIATE DATE				
N 446	Continued From page 1			N 446					
	agency with the potential to affect all patients of the agency.								
	The findings include:								
	1. Employee A, on 1-22-13 at 10:00 AM, indicated employee B was pending approval from the Indiana State Department of Health for the position of alternate director of nursing, No one currently was in the alternate director of nursing position.								
	2. On 1-23-13 at 11:00 AM, Employee A indicated that Employee B failed to meet qualification standards for the alternate director of nursing position per the Indiana Department of Health correspondence dated 1-7-13. Employee A indicated agency management felt the failure of Employee B to meet required standards for the alternate director of nursing position was due to Employee B not having a current Indiana nursing license. Employee A indicated Employee B was in the process of obtaining a nursing license for Indiana.								
	caring for patients in I Indiana licensure, cer	180, undated, titled states, "All employees Indiana shall be subjectification, or registration respective service."							
	Personnel file B failed to evidence a current Indiana license.								
N 454	54 410 IAC 17-12-1(d) Home health agency administration/management Rule 12 Sec. 1(d) The person or similarly qualified alternate shall be on the premises or capable of being reached immediately by phone,		N 454			2/11/13			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/ IDENTIFICATION NUMB			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
012591				B. WING	01/23/20	01/23/2013	
NAME OF PROVIDER OR SUPPLIER			STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
DINAMIC HEALTH CARE INC			7826 CALU MUNSTER,	IMET AVE STE IN 46321	E C		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE C	(X5) OMPLETE DATE
N 454	Continued From page	2		N 454			
	must be able to: (1) respond to an em (2) provide guidance (3) answer questions (4) resolve issues;	to staff; ;; and mount of time, given th					
	This RULE is not met as evidenced by: Based on personnel record and policy review and interview, the agency failed to ensure the agency had an alternate director of nursing for 1 of 1 agency with the potential to affect all patients of the agency.		ency				
	The findings include:						
	1. Employee A, on 1-22-13 at 10:00 AM, indicated employee B was pending approval from the Indiana State Department of Health for the position of alternate director of nursing, No one currently was in the alternate director of nursing position.		ne one				
	nursing position per the Health correspondence A indicated agency memployee B to meet alternate director of nemployee B not havir license. Employee A	• •	of coyee ure of the e to rsing was				

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STATE FORM FORM 16899 7FVG11 If continuation sheet 3 of 5

Indiana State Department of Health

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIP	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
				A. BUILDING				
		012591		B. WING		0.	1/23/2013	
NAME OF B	20,4050 00 01001150	012031	etheet ann	DESCRIPTION	TE ZID CODE		1/23/2013	
NAME OF PE	ROVIDER OR SUPPLIER			RESS, CITY, STA				
DINAMIC	HEALTH CARE INC		7826 CALU MUNSTER,	MET AVE STE IN 46321	: C			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF C	ORRECTION	(X5)	
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX TAG	(EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	IE APPROPRIATE	COMPLETE DATE	
N 454	Continued From pa	age 3		N 454				
	"Personnel Record caring for patients Indiana licensure, or required to perform	*D-180, undated, titled Is" states, "All employees in Indiana shall be subject certification, or registration in the respective service." Is failed to evidence a curre	et to n					
N 522	410 IAC 17-13-1(a) Patient Care			N 522			2/11/13	
	Rule 13 Sec. 1(a) Medical care shall follow a written medical plan of care established and periodically reviewed by the physician, dentist, chiropractor, optometrist or podiatrist, as follows:							
	This RULE is not met as evidenced by: Based on clinical record and policy review and staff interview, the agency failed to ensure visits had been provided as ordered on the plan of care in 2 (#2 and #3) of 3 records reviewed of patients receiving more than one service with the potential to affect all of the agency's patients.							
	The findings include:							
	1. Clinical record number #2, start of care (SOC) 3-13-12, included a plan of care for the certification period 11-8-12 to 1-6-13 with orders for the skilled nurse to visit one (1) time a week for nine (9) weeks and the home health aide was to visit one (1) time weekly for 9 weeks. The record evidenced a home health aide visit was missed during week 1 (11/8/12-11/10/12) and week 8 (12/23/12-12/29/12). A skilled nursing visit was missed week 9 (12/30/12-1/5/12.							
		on 1/23/13 at 11:00 AM, ted there was no other						

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
040504			B. WING		0.4/0.0/0.4.0		
012591			STREET ADDI	RESS, CITY, STA	TE ZIP CODE	01/23/2013	-
				MET AVE STE			
DINAMIC	HEALTH CARE INC		MUNSTER,	IN 46321			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOLE CROSS-REFERENCED TO THE APPRODEFICIENCY)	JLD BE COMPLETE	:
N 522	Continued From page	e 4		N 522			
	documentation available for the medical record and the visits were missed. 2. Clinical record number #3, SOC 2-23-12, included a plan of care for the certification period 12-19-12 to 2-16-13 with orders for the skilled nurse to visit one (1) time weekly for nine (9) weeks. The record included documentation of a missed skilled nursing visit week 1 (12/19/12 to 12/22/12) and week 3 (12/30/12-1/5/13). A. The record evidenced a home health aide visit was made 12/19/12, 12/24/12, 12/26/12, 1/2/13 and 1/7/13. The plan of care failed to evidence orders for home health aide services. B. Employee A, on 1/23/13 at 11:00 AM, indicated there was no other documentation available that indicated the patient was to have home health aide services. The home health aide services had been provided without an order.						
	Home Health-Plan of shall follow a written restablished and perio	undated, titled "Dinami Care states, "Medical of medical plan of care dically reviewed by the iropractor, optometrist of	care				

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